Your Benefit Summary

PEBB Statewide Plan

Part-Time Employees; Retirees

What You Pay In-Plan	What You Pay Out-of-Plan	Annual In-Plan Out-of-Pocket Maximum	Annual Out-of-Plan Out-of-Pocket Maximum	Lifetime Maximum Benefit
20% coinsurance	50% (coinsurance (UCR applies)	$2,000 per person $6,000 per family (3 or more)	$4,000 per person $12,000 per family (3 or more)	$2,000,000

Important information about your plan

This summary provides only highlights of your benefits. **Please note: this plan pays 50 percent of the first $1,000 of eligible expenses incurred from preferred and non-preferred providers per person, and $3,000 per family each calendar year.** Benefits are then paid as indicated in the following summary. To view all your plan details, including your Member Handbook, register for myProvidence at **www.providence.org/php/getstarted**.

- Not sure what a word or phrase means? See the back for definitions used in this summary.
- Some services and penalties do not apply to out-of-pocket maximums.
- Benefits for out-of-plan services are based on Usual, Customary & Reasonable charges (UCR).
- Limitations and exclusions apply to your benefits. See your Member Handbook for details.

PEBB Statewide Plan Benefit Highlights

You pay the following for covered services:

	In-Plan Cost (for participating provider)	Out-of-Plan Cost (for non-participating provider)
Physician / Provider Services		
• Office visits and procedures	20%	50%
• Periodic health exams, well-baby care (Covered according to plan schedule; includes related lab and X-ray.)	Covered in full	50%
• Routine immunizations, shots	Covered in full	50%
• Colorectal cancer screenings	Covered in full	50%
• Prostate cancer screenings	Covered in full	50%
• Allergy shots, serums, injectable medications	20%	50%
• Inpatient hospital visits	20%	50%
• Surgery, anesthesia	20%	50%
• E-visits to a participating provider	Covered in full	Not covered
Women's Health Services		
• Annual gynecological exams (calendar year), Pap tests	Covered in full	50%
• Follow-up visits after annual gynecological exam	20%	50%
• Mammogram screening (according to schedule)	Covered in full	50%
Hospital Services		
• Inpatient care, observation, maternity care	20%	50%
• Rehabilitative care (30 days per calendar year; 60 days head/spinal cord injuries)	20%	50%
• Skilled nursing facility (180 days per calendar year)	20%	50%
• Bariatric surgery	20%	Not covered
Maternity		
• Prenatal and postnatal visits, delivery	20%	50%
• Routine newborn nursery care	20%	50%
Medical Supplies and Equipment		
• Durable medical equipment and supplies	20%	50%
• Diabetic supplies	Covered in full	Covered in full
Emergency / Urgent Care / Ambulance Services		
• Emergency services (emergency medical conditions only)	20%	20%
• Urgent care services (non life-threatening illness/minor injury)	20%	50%
• Ambulance services (emergency transportation only)	20%	20%

PEBB Statewide Plan Benefit Highlights (continued)	In-Plan Cost	Out-of-Plan Cost
Other Covered Services		
• X-ray, lab services	20%	50%
• Imaging services (PET, CT, MRI)	20%	50%
• Outpatient rehabilitative services (60 visits per calendar year)	20%	50%
• Outpatient surgery, dialysis, infusion, chemotherapy, radiation therapy	20%	50%
• Temporomandibular joint (TMJ) services	20%	50%
• Home health care	20%	50%
• Hospice care	Covered in full	Covered in full
• Self-administered chemotherapy (Up to a 30-day supply from a designated participating pharmacy.)		
-Generic drugs	$10	N/A
-Formulary brand-name drugs	$50	N/A
-Non-formulary brand-name drugs	$100	N/A
• Chiropractic, naturopathic, acupuncture*	50%	50%
• Infertility*	50%	50%
• Hearing aids* (up to $4,000 every four calendar years)	10%	10%
• Hearing exam*	15%	50%
• Free & Clear® smoking cessation program	Covered in full	Covered in full
• Weight Watchers® program (Employees only; up to four programs per calendar year.)	Covered in full	Covered in full
** Does not apply to out-of-pocket maximum*		
Mental Health / Chemical Dependency (To initiate services, you must call 1-800-711-4577. All inpatient, residential, and day or partial hospitalization treatment services must be prior authorized.)		
• Outpatient services	20%	50%
• Inpatient hospital services and residential/day services (Residential services limited to 180 days per calendar year.)	20%	50%

Your guide to the words or phrases used to explain your benefits

Coinsurance
The percentage of the cost that you may need to pay for a covered service.

Out-of-pocket maximum
The limit on the dollar amount you will have to spend for specified covered health services in a calendar year. Some services and expenses do not apply to the out-of-pocket maximum. See your Member Handbook for details.

Copay
The fixed dollar amount you pay to a health care provider for a covered service at the time care is provided.

In-plan benefit
The in-plan benefit is an extensive network of highly qualified physicians and health care providers, also known as participating providers, available to you by your plan. Generally, your out-of-pocket costs will be less when you receive covered services from participating providers. To find a participating provider, go to www.providence.org/php/providerdirectory.

Lifetime maximum benefit
The total dollar amount of benefits that you can receive from your plan during your lifetime.

Non-participating provider
Any health care professional who does not participate in Providence Health Plan's network of participating physicians and providers of health care services.

Out-of-plan
Refers to services you receive from a non-participating provider. Your out-of-pocket costs are generally higher when you receive covered services from non-participating providers. To find a participating provider, go to the online directory at www.providence.org/php/providerdirectory.

Participating provider
A physician or provider of health care services who belongs to the Providence Health Plan participating provider network. To find a participating provider, go to the online directory at www.providence.org/php/providerdirectory.

Prior authorization
Some services must be pre-approved. In-plan, your provider will request prior authorization. Out-of-plan, you are responsible for obtaining prior authorization, or coverage for services may be denied.

Self-administered chemotherapy
Oral, topical or self-injectable medications that are used to stop or slow the growth of cancerous cells.

Usual, Customary & Reasonable (UCR)
Describes predefined charges established by your plan for services that you receive from an out-of-plan provider. When the cost of out-of-plan services exceeds UCR amounts, you are responsible for paying the provider any difference. These amounts do not apply to your out-of-pocket maximums.

Contact us

Headquartered in Portland, our customer service professionals have been proudly serving our members since 1986.

Customer Service: 1-800-423-9470
TTY: 503-574-8702 or 1-888-244-6642

Have questions about your benefits and want to contact us via e-mail? Go to our Web site at: www.providence.org/php/contactus.